



A Sempra Energy utility

20% CARE DISCOUNT APPLICATION

CALIFORNIA ALTERNATE RATES FOR ENERGY

The Gas Company's California Alternate Rates for Energy (CARE) program provides a 20% discount on the monthly gas bill for eligible households. To see if you qualify, check the requirements shown below. Please complete the application and return it in the envelope provided. Once your completed and signed application is approved by The Gas CompanySM, you will receive the CARE discount from your property owner/manager. You and your property owner/manager will be notified whether or not you are approved for the discount.

Or apply online at <http://www.socalgas.com/assistance/care/>

HOW TO QUALIFY FOR THE CARE DISCOUNT:

<p>PUBLIC ASSISTANCE PROGRAMS:</p> <p>If you or someone in your household participates in any of these programs</p> <p>Medicaid, Medi-Cal, Healthy Families A&B, Women, Infants, & Children (WIC), CalWORKs (TANF), Tribal TANF, Head Start Income Eligible - Tribal Only, Bureau of Indian Affairs General Assistance, CalFresh / SNAP (Food Stamps), National School Lunch Program (NSLP), Low Income Home Energy Assistance Program, Supplemental Security Income (SSI)</p>	OR	<p>MAXIMUM HOUSEHOLD INCOME*: (effective June 1, 2011 to May 31, 2012) *current household income from all sources before deductions</p> <table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 60%;">Number of Persons in Household</th> <th style="width: 40%;">Total Annual Income</th> </tr> </thead> <tbody> <tr> <td>1-2</td> <td>\$31,800</td> </tr> <tr> <td>3</td> <td>\$37,400</td> </tr> <tr> <td>4</td> <td>\$45,100</td> </tr> <tr> <td>5</td> <td>\$52,800</td> </tr> <tr> <td>6</td> <td>\$60,500</td> </tr> <tr> <td>Each additional household member, add</td> <td>\$7,700</td> </tr> </tbody> </table>	Number of Persons in Household	Total Annual Income	1-2	\$31,800	3	\$37,400	4	\$45,100	5	\$52,800	6	\$60,500	Each additional household member, add	\$7,700
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CONDITIONS FOR PARTICIPATION

This address must be your primary address. / You must not be claimed as a dependent on another person's income tax return other than your spouse. / You must recertify your application when requested. / You must notify The Gas Company within 30 days if you no longer qualify. / You may be asked to verify your eligibility for CARE.

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

Energy Savings Assistance Program: Offers no-cost energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repairs to eligible low-income home-owners and renters. For more information, please call 1-800-331-7593.



Medical Baseline: Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

LIHEAP: Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Dept. of Community Services and Development at 1-866-675-6623.

California Lifeline: A discounted telephone access for customers meeting similar income guidelines to CARE. For more information, contact your local telephone service provider.

FOR INFORMATION ON CARE, CALL THE GAS COMPANY AT:

English: 1-800-427-2200	Mandarin: 1-800-427-1429	Spanish: 1-800-342-4545
Korean: 1-800-427-0471	Cantonese: 1-800-427-1420	Vietnamese: 1-800-427-0478
Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)		



CARE 20% Rate Discount Application

Form 6677-D EN (06/11)

Please use DARK ink and print clearly to ensure proper processing

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Correct way to mark circles: ●



1	Customer Name (as it appears on your bill):	
	Home Address (street, space #, city, zip):	
	Facility ID:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Phone Number:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	E-mail Address:	<input type="text"/>

2	Total # of adults and children in your household:	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> If more than 6: <input type="text"/>												
	<u>Are you (or someone in your household) enrolled in any of the following assistance programs?</u>	<input type="radio"/> YES (If yes, mark the program(s) of participation) ▼ <table border="0"> <tr> <td><input type="radio"/> Medi-Cal / Medicaid: Under Age 65</td> <td><input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP)</td> </tr> <tr> <td><input type="radio"/> Medi-Cal / Medicaid: 65 or older</td> <td><input type="radio"/> Supplemental Security Income (SSI)</td> </tr> <tr> <td><input type="radio"/> Healthy Families Categories A & B</td> <td><input type="radio"/> National School Lunch Program (NSLP)</td> </tr> <tr> <td><input type="radio"/> Women, Infants, and Children Program (WIC)</td> <td><input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA)</td> </tr> <tr> <td><input type="radio"/> CalWORKs (TANF) or Tribal TANF</td> <td><input type="radio"/> Head Start Income Eligible - Tribal Only</td> </tr> <tr> <td><input type="radio"/> CalFresh / SNAP (Food Stamps)</td> <td></td> </tr> </table>	<input type="radio"/> Medi-Cal / Medicaid: Under Age 65	<input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP)	<input type="radio"/> Medi-Cal / Medicaid: 65 or older	<input type="radio"/> Supplemental Security Income (SSI)	<input type="radio"/> Healthy Families Categories A & B	<input type="radio"/> National School Lunch Program (NSLP)	<input type="radio"/> Women, Infants, and Children Program (WIC)	<input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA)	<input type="radio"/> CalWORKs (TANF) or Tribal TANF	<input type="radio"/> Head Start Income Eligible - Tribal Only	<input type="radio"/> CalFresh / SNAP (Food Stamps)	
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3	Do you agree to the following? Please read and sign below. I state that the information I have provided in this application is true and correct. I agree to provide proof of CARE eligibility if asked. I agree to inform The Gas Company if I no longer qualify to receive the discount. I understand that if I receive the discount without qualifying for it, I may be required to pay back the discount I received. I understand that The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs.
	Signature: <input checked="" type="text"/> _____ Date: <input type="text"/> / <input type="text"/> / <input type="text"/>